DOCUMENT RESUME

ED 313 202 RC 017 339

AUTHOR Link, Emerson A.
TITLE Mental Health Services to Rural Consumers. Lessons Learned from a Four Year Iowa Farm Crisis Project.
SPONS AGENCY Iowa State Dept. of Human Services, Des Moines.
PUB DATE 24 Jul 88
NOTE 6p.; Paper presented at the Annual National Institute on Social Work and Human Services in Rural Areas (13th, July 24-27, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adult Education; *Community Health Services; *Delivery Systems; Farmers; Health Education; *Mental Health; Mental Health Programs; Outreach Programs; Postsecondary Education; Psychiatric Services; Rural Areas; *Rural Population
IDENTIFIERS Farm Crisis; Iowa; *Service Utilization

ABSTRACT

The Southwest Iowa Mental Health Center recently completed a 4-year project to increase use of mental health services by normally reluctant rural populations and to increase coping ability among persons affected by the farm crisis. During the first 2 years, program goals included aggressive outreach to potential patients, mental health education seminars for non-mental health professionals, stress management workshops for at-risk farmers and other distressed persons, mental health treatment, and development of independent support groups. These development activities created a tremendous unfilled demand for psychiatric treatment and consultation services. During the last 2 years, the program sought to meet this demand by obtaining the services of a resident psychiatrist from a nearby university and by opening four satellite offices. The Center's experiences have shown that increasing delivery of effective mental health services to rural residents requires attention to both service delivery issues and treatment issues. Service delivery issues include (1) person-to-person outreach, (2) availability of services at the client's site, (3) extensive public relations to maintain high visibility for services, (4) satellite offices that offer both accessibility and a measure of anonymity to clients, (5) awareness that stress management and depressive symptoms are of prime interest for rural persons, and (6) a system that provides multiple services at one location. Treatment issues include: (1) alleviation of stress as the most important goal, (2) acceptance of emergency services as legitimate treatment, (3) diagnosis and treatment of the situation alone in some cases, (4) economics as the incentive for farmers to use mental health services, and (5) the importance of support groups. (SV)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED313202

MENTAL HEALTH SERVICES TO RURAL CONSUMERS-- LESSONS LEARNED FROM A FOUR YEAR IOWA FARM CRISIS PROJECT

By

Emerson A. Link, MSW

This project was funded by grants from the Division of Mental Health/Mental Retardation/ Developmental Disabilities of the Iowa Department of Human Services

In 1984, Southwest Iowa Mental Health Center sought and received a grant from the Division of Mental Health/Mental Retardation/Developmental Disabilities of the Iowa Department of Human Services to develop and deliver increased mental health services to the rural agricultural populations in the Center's catchment area. This was the first of four one-year grants made to the Center to focus on those agricultural populations. The first two years, emphasis was placed on both the delivery of therapeutic services and the development of increased utilization by persons effected by the economic problems created by the "farm crisis". The second two years, developmental activities were deemphasized in favor of focusing on the delivery of psychiatric services to the agricultural population. This was done, partly because the Center recognized a demand for psychiatric services which was unable to be met during the previous two years; and partly because of local and State funding constraints on continuing the same program beyond the initial two years.

Now that we have had the opportunity to look back on four years of specialized rural services, we have drawn some conclusions which may be helpful to other mental health professionals in other parts of rural America.

During the time of our grants, our intention was to increase the utilization of services by those populations which normally tend to shun mental health services. In addition, strengthened stress coping ability was the goal of treatment and education for those persons connected with agriculture.

Five major sets of activities were aggressively pursued to accomplish the goals of the program during years 1 and 2:

1. Aggressive Outreach to potential patients
2. Mental Health Education for non-mental health professionals
3. Stress Management Workshops
4. Mental Health Treatment
5. Support Groups

BEST COPY AVAILABLE

PC 017339

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Emerson A. Link
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Outreach to potential patients was accomplished with the hiring of a therapist whose office was more often the patient's home than the office at the Center. In the classical tradition of community organization, the therapist developed relationships with persons in agriculture at the local community level which were utilized at later times for referral of farm families that were in need. Her interventions consisted not only of the traditional therapy model and of localized educational presentations, but also of support and hand-holding at farm sales, in the courtroom, and wherever else the client happened to be at their time of need. It was this "local availability" that often made the difference between the family that received the services that they needed and the family that didn't. This, perhaps, was the one most significant successful strategy we invoked for servicing this most reluctant population.

Seminars for non mental health professionals were conducted with the purposes of (1) increasing these persons awareness of mental health issues in the agricultural population, (2) helping them to be able to identify symptoms of distress in their own clients, and (3) providing information on how and where to make referrals. A secondary and unplanned outcome of these seminars which proved to be very valuable was the opportunity the seminars afforded for non mental health professionals to vent their own frustrations and fears about the agricultural crisis. Bankers, in particular, seemed to benefit from utilizing these seminars in a quasi-group therapy format.

Stress Management workshops were designed to be offered to "at risk" farmers and other distressed persons whose symptoms appeared to not yet warrant individual treatment. The workshops were designed to give participants an increased knowledge about and capability to handle intense stress.

Treatment was handled either on-site, at the local level, or by other therapists at one of the Center's three offices. Often, the potential client would only agree to treatment on their own site, but would later be willing to be serviced in one of the Center's offices after the client became comfortable with receiving mental health services.

During the course of the first two years of our project a total of eight support groups were started in the Center's catchment area. These were designed to be self-maintained with occasional input by various professional disciplines as requested. Initial start-up was facilitated by Center staff who then remained as consultants only by request. The purpose of the support groups was to give distressed individuals and families a forum in which to discuss their fears and frustrations, to create a bond of unity among persons who traditionally tended to isolate themselves when problems arose, and to facilitate actions by the group.

During years 3 and 4 of the project two major sets of activities were pursued while the emphasis on development activities was dropped:

1. Psychiatric Treatment
2. Psychiatric Consultation

Development activities during the first two years of this project had created a tremendous unfilled demand for psychiatric treatment and consultation services. The success of the program brought with it the dilemma of how to adequately meet requests for service from a population now more willing to utilize mental health professionals. To provide for the additional demand for psychiatric services, we negotiated an agreement with the Psychiatric Residency program of Creighton University, in Omaha, some sixty miles distant. They provided a resident on a 6-month rotating basis for the provision of outpatient and consultation services in the Center's catchment area. This resident was under the supervision of the Center's full-time Medical Director. In addition, to maintain "local services", we opened four additional One-half-day-per-month "remote satellites" in smaller towns in our catchment area.

After a total of four years, we believe that we have gained some insight into how to most effectively bring mental health services to rural agricultural populations. These insights are based upon the following 6 broad assumptions based on our experience in Southwest Iowa rural communities:

1. Under normal conditions, farm families will attempt to work out their own problems and will not ask for help from a mental health professional.
2. Inability to cope is viewed as a personality flaw and only the most adverse of circumstances overcomes the resistance to and embarrassment of seeking help.
3. Men are tied to a work ethic which says, "I will not be a failure if I work hard enough". When hard work does not yield success, the farmer undergoes extremely high levels of guilt and hopelessness.
4. Unresolved family conflicts, while maintained at a barely tolerable level during good times, cannot withstand unremitting economic stress.
5. Farmers tend to view the cost of mental health services in both monetary and temporal perspectives.
6. The familiarity of the rural community makes it hard for persons to seek mental health services and maintain their anonymity.

On the basis of these assumptions and the Center's success in meeting its goals, the following conclusions are presented for consideration:

SERVICE DELIVERY ISSUES

1. Person to person outreach is critical to maintain a level of utilization commensurate with need. Without personal contact at a local level, the demand for services falls far short of the need.
2. Mental health services need to be available to the client on his site. For many persons, on-site services is the only acceptable beginning for treatment.
3. Extensive public relations on a continuous basis is necessary to maintain a high level of visibility for services. Most persons pay no attention to what's available until they need it. Financial resources need to be committed to maintain that visibility.
4. Satellite offices need to be accessible to, but not in the patients' territory. Our experience with our remote satellites was that they were seldom used because they were too close to the patients' own communities. Clients were willing to go some extra miles to an office where they felt they had less chance of being identified by their own community members.
5. Education on stress management and awareness of depressive symptoms are the prime subjects of interest for rural persons. Stress is an "acceptable" problem that everyone has to deal with from time to time, and potential clients can attend educational seminars on stress without admitting to any problems themselves. Interest in depression is high because potential clients always "know someone who needs to know this information". In addition, these two subjects are the most useful for encouraging appropriate preventative responses to stress without mental health professional intervention and for self-diagnosis and referral for depressive symptoms.
6. A service system which includes one-stop access to therapy, legal services, economic counseling, and advocacy will circumvent the frustrations that occur when the rural client is shunted from resource to resource, often with little satisfaction from any of the resources. Simply negotiating a system which is scattered and ill-coordinated is often a major barrier to the potential client.

TREATMENT ISSUES

1. Alleviation of stress is the most important goal. Many rural clients would never have used our services without the unremitting economic distress that fractured the rest of their fragile life systems. Their prime consideration in the decision to utilize mental health services is often simply a desire for the relief of that distress. At issue is whether the client is allowed to determine whether the focus of service goes beyond that level.
2. Emergency services and crisis lines will provide temporary, and in some cases, permanent relief from distress. Mental health professionals need to be able to accept such brief encounters as legitimate methods of treatment.
3. In many cases, diagnosis and treatment of the <u>situation alone</u> is the key to successful treatment.
4. The appeal to utilize mental health services may be done on the basis of economics for the farmer.
5. Groups provide an invaluable resource for the treatment of the hopelessness that rural persons feel. Individual therapy, alone, further isolates the client from contact with his fellow economic victims. Groups provide a way for clients to not only share their problems, but also their solutions.

Attention to both the service delivery issues and the treatment issues presented in this paper should yield positive results in getting effective services to a greater number of rural residents. However, the final and the major overriding issue for implementing such a system as we are suggesting is the commitment that funding sources have for such aggressive and comprehensive outreach to the rural community. If the mental health system is to really adequately address the need among rural residents for mental health services, there must be a long range commitment of financial resources to such a program. The appeal to local funding sources must be made on the basis of cost saving rather than on the basis of obligation. If the expense of the service delivery system can be justified and mental health professionals are committed to a community outreach model, then services to the rural community will successfully turn need into demand and demand into serviced clients.